LMFT SUPERVISOR OF SUPERVISION CHECKLIST
FORM SUP 7

- □ Form MFT 1 - Completed General Information Form
- □ Form MFT 8 - Application for LMFT Supervisor of Supervision
- □ $50 non refundable application and approval fee

See application instructions for further details.
DO NOT SUBMIT AN INCOMPLETE APPLICATION
ALL INCOMPLETE APPLICATIONS WILL BE RETURNED

MFT 1
General Information Form

Alabama Board of Examiners in Marriage and Family Therapy
P.O. Box 240066
Montgomery, AL 36124-0066
Phone: (334) 215-7233
Fax: (334) 215-7231
E-mail: paula.scout@mft.alabama.gov
Website: www.mft.state.al.us

Application for:
- ☐ Marriage and Family Therapy Intern (MFT Intern)
- ☐ Marriage and Family Therapy Associate (MFT Associate)
- ☐ Permission to sit for the Marriage and Family Therapy
- ☐ Licensed Marriage and Family Therapist (LMFT)
- ☐ Licensed Marriage and Family Therapist By Endorsement

Name:_____
Last First Middle/Maiden

Social Security Number:_____ **Date of Birth**:_____

Gender: ☐ Male ☐ Female

Have you ever held an Alabama Professional License Before? ☐ No ☐ Yes, as follow(s):

Name of Profession:_____ License #:_____

Name of Profession:_____ License #:_____

Name of Profession:_____ License #:_____

Work Mailing Address:

E-mail: _____

Street:_____

City:_____

State:_____ Zip:_____

County:_____

Telephone:_____

Fax:_____

Home Mailing Address:

E-mail: _____

Street:_____

City:_____

State:_____ Zip:_____

County:_____

Telephone:_____

Fax:_____

Preferred Mailing Address (The address listed here will be public.):
☐ Work ☐ Home

APPLICATION FOR LMFT SUPERVISOR OF SUPERVISION
FORM SUP 8

Name:_____MFT License #:_____
Date designated LMFT Approved Supervisor:_____

SUPERVISOR EXPERIENCE:
List in reverse chronological order (most recent first) all places of professional employment experience in which you provided MFT supervision, indicating the number of supervisee hours of supervision along with your other responsibilities/activities. PLEASE SHOW MONTH AND YEAR FOR EACH. Use additional sheets if necessary.

1. Position:_____Phone:_____
   Organization:_____
   Address:_____
   Dates of Employment:_____to_____
   Contact Person:_____
   Primary Responsibilities/Activities:_____
   _____
   # of hours providing clinical services per week:_____
2. Position:_____Phone:_____
   Organization:_____
   Address:_____
   Dates of Employment:_____to_____
   Contact Person:_____
   Primary Responsibilities/Activities:_____
   _____
   # of hours providing clinical services per week:_____

SUPERVISON EXPERIENCE:
List names of MFT supervisees for whom you have provided the required 100 hours of MFT supervision beyond the required minimum of 180 hours of supervision to become an LMFT Approved Supervisor:

Name	Dates of Supervision	Hours of Supervision
	_____to_____	
	_____to_____	
	_____to_____	
	_____to_____	
	_____to_____	

Total: _____

I certify that the information on the reverse side is accurate, that I have provided a minimum of 280 hours of MFT supervision, and that I am qualified to provide MFT supervision of supervision to MFT supervisors in training in accordance with the ABEMFT Rules and Regulations. I further certify that I have read the responsibilities and guidelines for the provision of supervision.

_____ _____
Signature Date